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ABSTRACT

Most scholars adopt one of two orientations when explaining why some occupations are more skilled than others: realism or constructionism; both views would benefit from a consideration of interactionism. No occupations are more likely to have to negotiate their status than those that emerge from amateur or voluntary work. Members of such occupations, such as emergency medical technicians (EMTs), must convince their audiences in the course of face-to-face interaction that they have skill or knowledge sufficient to provide for a fee what has traditionally been free. A study focused on two commercial and two volunteer EMT agencies. The commercial agencies' actual proficiency was insufficient for establishing their reputation since some volunteers possessed equivalent skills and most of the emergency calls did not require advanced training. EMT societies made no distinction between paid and volunteer providers, and the public remained largely unaware of differences. To understand how and why the paid EMTs were acquiring a reputation for greater skills required consideration of cultural understandings, institutional supports, tasks, and even competencies as resources whose meaning and use were discovered in the course of ongoing interaction. Both groups' reputations were affected by interactions involving EMTs and interactions and interpretations of nurses, physicians, and other audiences. (Contains 90 references.) (YLB)

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Practice Makes Perfect: Emergency Medical Technicians and the Social Negotiation of a Skilled Occupational Identity

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I. Introduction

In the spread of microelectronics, the decline of smokestack industries, and the growth of service and information sectors of the economy, some social scientists have seen the rise of a "post-industrial" society dominated by skilled "knowledge workers" (Touraine 1971; Bell 1973; Mallet 1975; Piore and Sabel 1984; Adler 1987; Johnson and Packer 1987; Carnevale 1990). Others have envisioned precisely the opposite, an increasingly less skilled and underemployed workforce (Braverman 1974; Poulantzas 1975; Kraft 1978; Zimbalist 1979; Bluestone and Harrison 1982). Although the jury is still out, accumulating evidence indicates that reality may be more complex than either scenario. Case studies have shown that some occupations have been deskilled by microelectronics (Wallace and Kalleberg 1982; Crompton and Jones 1984), while other occupations have found their skills enlarged or transformed (Attewell 1987; Barley 1988; Zuboff 1988). Aggregate studies paint a similar picture. Census data indicate that the percentage of the workforce employed in traditionally "skilled" categories has grown steadily since 1950 (Bishop and Carter 1991; Barley 1991). Studies of job requirements also depict a general upgrading of skills, even among the clerical and manual workforce (Diprete 1988; Cappelli 1991; Howell and Wolff 1992). Yet, survey data indicate that the predominant trend has been accompanied by a secondary trend toward less skilled jobs (Myles 1988; Gallie 1991). Although one might conclude that the average job is therefore becoming more skilled even as the occupational distribution becomes bimodal, beneath such an empirically cautious statement lurks a cultural quagmire.

There are only three paths by which a workforce can become more skilled: the expansion of occupations already considered to be skilled, the upskilling of formerly less skilled occupations, and the granting of skilled status to new occupations. The first route poses few cultural problems because it leaves intact existing understandings of an occupation's position in the division of labor. By contrast, upskilled and new occupations pose interpretive quandaries. In the first instance, strong precedents may exist for viewing the work as less skilled than it has become; in the second, there may be no precedents whatsoever. In either case, whether the members of such occupations will garner the

wages and other privileges traditionally reserved for skilled work seems uncertain.

The issue is not simply one of social and economic justice, no matter how important these might be. When a culture's evaluation of an occupation is incommensurate with its requirements, recruitment and retention become problems. The question of how an occupation acquires a reputation for skill is therefore of more than passing interest not only for members of the occupation, but for society, itself, which must somehow redeploy workers from declining to expanding lines of work. Current notions of how occupations acquire skilled status shed little light on the predicament of recently upskilled or nascent occupations either because they ignore the cultural component of skilled status altogether or because they require more cultural capital than such occupations initially possess.

II. Toward a Contextual Understanding of Skilled Status

Realism

Implicitly or explicitly, most scholars adopt one of two orientations when explaining why some occupations are more skilled than others: realism or constructionism (Attewell 1990; Vallas 1990; Spenner 1990). Realism, the most prevalent account, rests on the presumption that skills are abilities or bodies of knowledge with objective existence. Although economists, psychologists, and sociologists differ over whether skills are best viewed as attributes of jobs or of job holders, all realists assume that skills can be ranked by complexity and scarcity. Realists therefore reserve skilled status for occupations whose competencies appear to be rare, difficult to acquire, and crucial for achieving some social or economic goal.

Although realism resonates with common sense, it suffers from several weaknesses. Realism implies that an occupation's reputation should rise and fall as its member's competencies wax and wane. In other words, skilled status should vary much like a price in a market of perfectly knowledgeable actors. However, even if one grants that competencies can be objectively assessed, there is no guarantee that any particular assessment will be accurate. Inaccurate assessments are especially likely in the case of new or recently upskilled lines of work. In each case, people may be asked to perform tasks that no one has done before. When neither practitioners nor evaluators understand what the work requires, it is unclear how skilled status can be "realistically" attributed.

Even more troubling for realism is accumulating evidence that skilled performances are based on tacit knowledge and contextually triggered activity (Kusterer 1978; Scribner 1986; Harper 1987; Lave 1988; Cambrosio and Keating 1988; Orr 1991). If competencies are largely tacit, not only are evaluators unlikely to comprehend what a

task involves, but the occupation's members may themselves be unaware of what they actually do. Obscure competencies challenge realism more severely than the unfamiliar. The unfamiliar may eventually become commonplace, but that which cannot be articulated must, by definition, remain unknown.

Most problematic, however, is realism's tendency to deny culture any role in the attribution of skill. Realists have difficulty explaining why some occupations are less skilled than their tasks would seem to warrant. Occupations which enjoy skilled status but whose work revolves around widely distributed abilities also pose anomalies for the realist. The first type of anomaly is common among occupations populated by women (Roos 1981; Beechey 1982; Steinberg 1990); the latter occurs with some frequency in unionized plants (Turner 1962) and among the allied health professions.[1]

Constructionism

In response to realism's inadequacies, a number of scholars have argued that skill is best viewed as a social construction that may or may not coincide with complex or crucial competencies. Although few constructionists argue that skilled status is fictional, all agree that it is a product of social processes strongly influenced by cultural understandings, distributions of power, and social institutions. Constructionists differ according to which dynamics they emphasize.

Cultural theorists lay the burden of explanation on existing cultural templates for what does and does not constitute skilled activity. Feminist sociologists, in particular, have argued that practitioners are more likely to obtain a reputation for skill when they resemble members of occupations that have long enjoyed skilled status (Phillips and Taylor 1980; Beechey 1982; England et al. 1982; England and Dunn 1988). As Steinberg (1990) demonstrated, formal systems for determining skill often rely on taken-for-granted images of crafts, professions, and upper-level management. Consequently, skilled status and its attendant compensation are strongly associated not only with gender and educational credentials, but with such activities as administering budgets, working with machines, and interacting with persons in positions of authority. By comparison, verbal, social, and emotional competencies are devalued, in part, because they have been associated with "women's work" and, in part, because they are culturally and linguistically less well differentiated. The upshot is that occupations dominated by women are often treated as less skilled than those dominated by men, even when the latter perform less complex tasks.[2]

A second approach to the social construction of skill places political rather than cultural dynamics at center stage. From this perspective, skilled status is best understood as an outcome of power struggles between the members of an occupation, the managers of a firm, and those in related lines of work who wish to protect their turf (More 1982; Thomas 1992). Whether workers gain or forfeit a reputation for skill depends on the various parties' capacities to enforce their interests. Thus, the presence or absence of a skilled reputation is roughly equivalent to the presence or absence of power and control. Most research on the politics of skill has focused on how competing models of work relations are embodied in the design of technologies and jobs (Noble 1984; Shaiken 1984). Far less frequent have been studies that chart the ploys and counterploys of actors involved in struggles over the definition of skilled work (Kling 1980; Markus 1981; Kling and Iacono 1984; Gash 1987; Thomas 1992).

The most prominent and well developed literature on the social construction of skill emphasizes institutional dynamics. Here, too, skill accompanies power and control, but the path to dominance lies less in fighting endless

skirmishes than in building an unassailable fortress. Institutionalists submit that skilled occupations are those granted a jurisdiction over problems important in a society at a particular point in time (Abbott 1988). Skilled jurisdictions rest on a *perception* that practitioners possess rare and valuable expertise. Institutionalists have therefore made much of the resources that enable occupations to lodge and defend claims to expertise. However, aside from a handful of studies of how professionals enact expertise in face-to-face encounters (Sudnow 1965; Emerson 1970; Anderson and Helm 1979; Hosticka 1979), most institutionalists have framed resources in structural terms. From this perspective, occupations secure jurisdictions largely by developing organizational forms that enable them to monopolize the market for their services. Accordingly, institutionalists consider occupational associations, formal training programs, and state-mandated licenses to be crucial for the construction of a skilled identity. Although the institutional perspective has been nearly synonymous with the literature on professionalization (Friedson 1970; Elliot 1972; Johnson 1972; Larson 1979; Child and Fulk 1982), similar reasoning underwrites recent accounts of how the crafts have retained their status in the face of technological change (Penn 1982; Lee 1982).

Although constructionism has corrected for realism's largely asocial orientation, in the end, it too has failed to illuminate the predicament faced by nascent or recently upskilled occupations. Three problems have been particularly salient. First, if realists have assumed that reputations adjust too easily, constructionists have too readily implied the reverse. Dim hope of departure from the status quo is most noticeable among cultural theorists. To the degree that a theorist portrays cultural understandings as entrenched, he or she reduces an occupation's members to cultural prisoners who must accept, however begrudgingly, whatever reputation the culture hands them until the culture itself changes. Institutional theorists less obviously project a similar prognosis. By pegging skills to formal structures emblematic of crafts and professions, institutionalists foreclose skilled status to almost all occupations simply because such supports are difficult to obtain (Wilensky 1964). More subtly, institutionalists imply that a line of work can be skilled only insofar as it resembles work already perceived as skilled. Thus, institutional theory parallels cultural theory with the exception that it emphasizes structural rather than cognitive constraints.

Second, constructionists have typically begun tracking occupational dynamics far too late in their development to afford much insight into the situations that confront incipient lines of work. The gap is most evident in institutional accounts, although most cultural and political theories also presume that recognizable occupations already exist. To form an occupational society or union, establish a training program, or secure licensing requires collective action. At a minimum, practitioners must have developed an identity, and their relevant publics must have begun to concede that practitioners possess valuable skills. Otherwise, practitioners would have no platform for campaigning to solidify their jurisdiction. Yet, it is precisely this sort of cultural capital that fledgling occupations lack. Before practitioners can reap the benefits of institutional supports, engage in concerted political action, or even consider themselves an occupation, they already must have engaged in considerable footwork to build the public support and acquiescence that Hughes (1958) termed an occupation's "license and mandate."

Finally, in the act of calling attention to social and cultural processes, constructionists all too often have lost sight of the work that people do. Wittingly or unwittingly, papers on the social construction of skill read as if reputations were formed independently of tasks. Perhaps it is for this reason that social construction is frequently

dismissed as labelling theory. Although skilled status implies valuation, as More (1982) noted in his critique of the political perspective, it is difficult to comprehend how an occupation can maintain a reputation for skill unless members' tasks and competencies are somehow implicated. Rather than ignore the work that people do, it seems more reasonable to ask how people can parlay actual or imputed tasks into an occupation's reputation.

Social Construction in Action

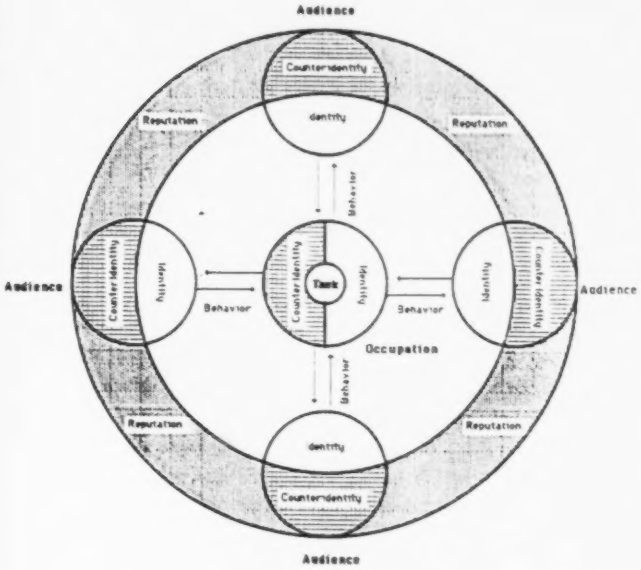
In short, to address the predicament faced by nascent or upskilled occupations, researchers may need to bridge realism and constructionism. Analysts who wish to study how reputations arise can afford to assume neither that the properties of tasks are self-evident nor that they are irrelevant. Instead, they must acknowledge that occupational reputations hinge on the work that people do, while recognizing that a task's meaning is socially rather than objectively given. The critical object of analysis might then become how practitioners employ the attributes of their work to acquire the cultural capital necessary for successfully claiming a skilled jurisdiction.

The rationale for placing human action at center stage is ultimately pragmatic. Because occupational change usually proceeds simultaneously in many locations, reputations are likely to develop concurrently on many fronts. Early practitioners in a particular locale may know only of themselves or, if they are aware that peers exist, they may know little about how those peers are perceived or how they do their work. Hence, those who wish to study how new or upskilled occupations acquire reputations may have little choice but to start by studying situated actions since there may be little else to study.

Figure 1 displays a situated model of reputational dynamics strongly rooted in interactionist theories of role and identity (Mead 1934; Goffman 1959, 1967; McCall and Simmons 1978; Strauss 1959; Strauss et al. 1964). The system pivots around the practitioner's work and is embedded in a social context composed of cultural and institutional forces. Because an occupation's birth occurs in many sites, any consistency across locales must be rooted either in the attributes of the task or in cultural and institutional dynamics. However, as Barley's (1986; 1990) studies of medical imaging devices indicate, even material forces are filtered though local actions where they are bent to context. Accordingly, the model treats neither task nor context as determinants, but as resources on which interested parties draw to negotiate an occupation's reputation. Tasks are pivotal not only because they shape what practitioners do, but because they define the audiences with whom practitioners must interact.

The circles in Figure 1 suggest that practitioners and audiences are best viewed as groups of structurally equivalent actors whose subcultures provide interpretive frames for making sense of self and others. Each frame has two crucial components, an *identity* and a set of *counteridentities*. An identity is the image that members have of themselves. Counteridentities are the images that members have of others. Identities and counteridentities emerge (and are confirmed or altered) in the round of daily life. They are grounded in the activities that warrant a group's being and encompass what members of an occupation say to each other about the nature of their work and the sort of person it takes to do the work well (Van Maanen and Barley 1984). As members encounter their audiences, identities solidify; for in the course of interaction members discover how they differ from their audience and, hence, who they are. Counteridentities are formed in the same way and consist of member's perceptions of how and why the audience is not like themselves. Identities and counteridentities are linked: elements of one often find their converse in the other simply because knowing "who

Figure 1
Interactional Model of an Occupational Reputation



Cultural and Institutional Context

one is" entails having an exemplar of "who one is not." Figure 1 signifies the interaction between practitioners and audiences with bi-directional arrows labeled "behavior." As does interaction in everyday life, the arrows knit the system into a structured but dynamic whole.[3]

An occupation's reputation ultimately rests on how various audiences perceive practitioners and their work. Accordingly, the band labeled "reputation" in Figure 1 incorporates only the audiences' counteridentities. If each audience's image is unique, the occupation can be said to have no reputation, at least in the traditional sense of the term. Conversely, if all audiences hold identical images, the occupation's reputation should be firmly ensconced. Because each audience stands in a different relation to the occupation, identical images are extremely unlikely. The strength of an occupation's reputation therefore depends on the extent to which the array of counteridentities becomes aligned.

From an interactionist perspective, three dynamics should foster alignment. First, as cultural theorists have emphasized, the more strongly the work resembles that of an occupation whose reputation is already fixed, the more the various counteridentities should coincide. However, even when members of the various audiences partake of the same culture, there are reasons to believe that cultural templates will operate unevenly. Some audiences are likely to be less aware of the template than others. Those unaware of a template cannot use it to infer the occupation's value. More importantly, because the audiences have different relationships with practitioners, some will find cultural and institutional understandings to be more (or less) descriptive of their experience with practitioners.

Second, counteridentities should converge to the degree that practitioners behave consistently with members of different audiences. Consistency may arise because practitioners fail to distinguish between audiences or because their behavior is constrained by technology, law, or other exogenous forces. Practitioners may even realize that their reputation is at stake and behave in a manner calculated to lead observers to conclusions consistent with their notion of self. Finally, practitioners may foster alignment by treating the members of one or more audiences as foils. For instance, practitioners may cast an audience of potential competitors as enemies and then encourage third parties to adopt a compatible point of view. Such a strategy could be pursued indirectly by inducing competitors to act like the practitioners claim they do in the hope that other audiences will draw appropriate conclusions. Alternately, practitioners may try to shape the perceptions of third parties directly by word and deed. Should powerful

competitors engage in similar tactics, the negotiation of a reputation may become a political struggle.

The importance of contextually embedded action to the allocation of skilled status is likely to vary by the circumstances that occasion a line of work. Abbott (1988) has noted that some occupational jurisdictions rest on material foundations. Because material foundations foster the illusion that the work has arisen *de novo*, such an occupation's mandate may appear clear-cut. For instance, occupations linked to scientific discoveries and technological discontinuities are commonly presumed to have had *de novo* births. In contrast, other occupations are born slowly as byproducts of social and organizational change. Examples include occupations formed because existing occupations have cast aside unwanted tasks or because organizations have encouraged functional specialization. In such instances, an occupation's license and mandate are more difficult to establish simply because any claim to expertise has less of an aura of factuality. The degree to which such occupations are treated as skilled should therefore be more tightly bound to situated actions and negotiations.

However, no occupations are more likely to have to negotiate their status than those that emerge from amateur or voluntary work. The transformation of unpaid work into full-time employment accounts for much recent growth in the service industries. Familiar examples include day care workers and home health aides. Occupations that emerge from unpaid work usually enjoy few institutional supports. Knowledge of relevant technologies and techniques may be widely distributed and potential clients are likely to have alternate sources of supply. In many instances, cultural biases may also hamper the occupation's ability to construct a skilled reputation. Thus, members of such occupations face the stiff task of convincing their audiences in the course of face-to-face interaction that they have skill or knowledge sufficient to provide for a fee what has traditionally been free. Such has been the case with paid Emergency Medical Technicians.

III. Emergency Medical Services

The work of the Emergency Medical Technician (EMT) emerged over the last twenty years as a byproduct of social movements that made a national priority and a medical problem of what had been a logistical issue: how to transport the sick and injured. Prior to World War II, few systems for transporting patients existed outside of large cities where hospitals sometimes operated their own ambulance services. In smaller towns and villages, patients might summon a funeral director whose hearse doubled as an ambulance.[1] But for the vast majority of Americans, particularly those in rural areas, family and friends were the only source of emergency transportation. Consequently, the best most patients could hope for was a smooth and timely ride.

As the interstate highway system expanded and automobile accidents became more common, the American public gradually awakened to the need for more responsive medical transport (Metz 1981; Crowley 1982; Brodsky and Hakkert 1983; Boyd 1983). During the late 1950s and early 1960s, volunteer rescue squads sprang up across the countryside as part of a grassroots effort to reduce fatalities. However, local initiatives remained largely uncoordinated until 1966 when Congress passed the National Highway Safety Act (NHSA) which mandated that each state devise a system for rescuing injured motorists. Most states rapidly adopted the volunteer rescue squad as their paradigm. The model allowed legislatures to comply with the intent of the NHSA by channeling federal funds to local communities which, in turn, could either distribute the funds to existing agencies or establish new ones. As a result, volunteer squads became even more common in rural and suburban communities. However, they proved less viable in the cities where volunteers were more difficult to recruit. City governments found that to comply with the NHSA they had to rely on paid ambulance drivers employed either by commercial agencies or by public fire and police departments. For the most part, the various types of agencies operated independently, even in regions where they coexisted.

By the 1970s the problem of timely response had been largely resolved, yet highway fatalities remained common. If mortality and morbidity were to be reduced further, advocates argued, medical care would have to be delivered at the scene. The move to "medicalize" (Bucher 1988) emergency transport began with a report issued by the National Academy of Sciences in 1966. The report argued that an accident victim's survival depended almost totally on untrained "ambulance drivers" and that there was a "need for a standard course of instruction . . . beyond . . . the Red Cross program in first aid" (National Academy of Science 1966, 14). Ideally, the report concluded, all emergency vehicles should be staffed by individuals with medical training. Because studies indicated that the probability of surviving a wound in Vietnam was greater than that of surviving an accident on the American highways, the report touted the combat medic as the model for delivering such care. If ambulances were staffed by paramedics who could deliver advanced life support in the absence of a physician, civilian fatalities might also be reduced.

Ultimately, it was the Emergency Medical Systems Act of 1973 that medicalized the transportation system. The Act recommended standards for training emergency medical service (EMS) personnel and placed responsibility for implementing the system in the hands of 304 administrative "regions." The Act's decentralized approach resulted in a proliferation of standards. By 1983, thirty different forms of certification existed across the country. Yet, despite such variation, each region implemented a nested system of training that allowed EMTs certified at different "levels" to administer ever more complicated treatments. In all regions, levels connoted "ranks": personnel certified at higher levels were made legally responsible for those at lower levels. Thus, the Emergency Medical Systems Act created a formal hierarchy among EMS practitioners based on breadth and depth of knowledge.

However, the regions made no formal distinctions between paid and voluntary agencies. Because identical training was offered to all personnel, neither paid nor volunteer EMTs could claim greater skill simply on the basis of access to training and certification. Moreover, because the states required all agencies to use similar equipment, status differences could not be grounded in differential access to resources. Even the medical community granted equal access to hospitals, dispatchers, and medical consultation. Medicalization therefore offered paid EMTs none of the formal supports that most other allied health professionals have used to construct skilled

identities. Over time, however, informal distinctions between paid and voluntary EMTs gradually arose.[5]

Because obtaining higher certification requires a considerable investment of time and effort as well as a willingness to accept personal liability, fewer volunteers have sought advanced training. As a result, the average paid EMT has become more highly certified than the average volunteer, even though most volunteer agencies have several members with advanced training. The differential propensity to be trained might have become little more than a statistical fact had the various agencies been allowed to continue to operate independently. However, to ensure that emergency services would be available at all times, most regions instituted "mutual aid systems."

Under a mutual aid system, all agencies are assigned territories, and calls are initially referred to the agency responsible for the area where the emergency occurs. When the assigned agency is unable to respond, a second agency is notified. Although no rules mandate that the second agency be a paid provider, exigencies often dictate otherwise. During the day it often proves easier to summon paid providers because employers are unwilling to allow volunteers to leave their jobs. Dispatchers are also likely to request backup from paid providers when volunteer crews encounter situations for which they are inadequately certified. Once on the scene, control generally shifts to the paid EMTs simply because they outrank the volunteers.

Although these informal structural conditions have given paid EMTs an edge in constructing a skilled identity, the advantage has been less than a *fait accompli* for several reasons. First, a commercial agency's typical case requires no more training than most volunteers possess. The workload consists largely of "routine transports" that require little or no medical intervention (Metz 1981). Second, professional EMS associations have consciously made an effort to treat paid and volunteer EMTs equally. Finally, and most importantly, popular culture has moderated the reputational advantage that higher certification might have otherwise afforded. The public is still largely unaccustomed to thinking of emergency personnel as providers of medical care. Instead, rescue personnel are viewed much like police and fire fighters (Crowley 1979). Although such occupations are not thought to be without skill, images of skill are less salient than images of altruism, bravery, and authority. The symbolics of EMS have actually reinforced this cultural template. Paid EMTs uniforms more closely resemble those of the police than those of a doctor or nurse. Ambulances have the same flashing red aura as all other emergency vehicles. Field conditions often require EMTs to act as agents of social control before they can deliver medical care, and patients almost always encounter EMTs in situations where their primary wish is to be delivered into the hands of a doctor. In other words, patients not only expect to be transported rather than treated, but most are unaware of any distinction between paid and voluntary EMTs. Objective differences in expertise therefore represent, at best, resources that paid EMTs can use to construct a skilled reputation.

To parlay such resources into an occupational mandate, paid EMTs must persuade at least three audiences that they are more capable than volunteers: doctors, patients, and the public at large. Volunteers, however, are unlikely to acquiesce to such assertions. Consequently, the construction of skilled identities has become a contested issue which, in the absence of strong institutional supports, is played out in the course of situated encounters between EMTs and their various audiences. The ploys and counterploys used by paid and volunteer EMTs to promote their preferred identities and counteridentities shaped the aura of day-to-day work in each of the EMS agencies we investigated.

IV. Sites and Methods

The study focused on two commercial and two volunteer agencies located in a single administrative region of a Northeastern state. Each agency was subject to the same certification procedures, used nearly identical protocols and answered to the same regulatory body. The first commercial agency, Jones, was a family-owned company in a city of 50,000 people. Jones employed 40 EMTs, seven of whom worked full time. The agency operated three ambulances and a flycar, a medically equipped Suburban used primarily on mutual aid calls. The vast majority of Jones' employees received their initial training as volunteers and many still served on volunteer squads after hours. Medco, the second commercial agency, was run by experienced EMTs whom the company's founders had appointed to managerial positions. Situated in a city of 155,000, Medco employed approximately 100 EMTs and operated a fleet of nine ambulances and two support vehicles. Although most of Medco's staff began as volunteers, few still served with volunteer agencies. The two volunteer agencies were attached to fire companies in townships surrounding the city served by Jones. The first, Lakeview, operated two ambulances and was staffed by 18 active members. The second, Maryville, had 28 active members and three ambulances.

The region in which the agencies were located recognized four levels of certification. *Basic EMTs* were trained to administer non-invasive first aid procedures such as cardiopulmonary resuscitation, oxygen therapy, extrication, bandaging, and splinting. *Intermediate EMTs* could establish intravenous lines, intubate via the trachea, defibrillate patients under limited conditions, and operate monitoring devices. By advancing to *critical care technician*, an EMT could administer a variety of drugs through a catheter and provide advanced life support in a wider variety of situations. Finally, EMTs certified as *paramedics* were allowed to administer narcotics and tranquilizers, treat children under the age of three, perform emergency tracheotomies, apply external cardiac pacing, and administer intramuscular and subcutaneous injections. Most EMTs who worked for the commercial agencies were certified as critical care technicians or paramedics. Most volunteers were either basics or intermediates, although some members of both squads had higher certifications.

The data were collected in three overlapping phases during an eleven-month period when the first author served as a participant observer in the four agencies. During the first four months of the study, Nelsen observed simultaneously at Jones and Lakeview. In the fifth month she began three formal EMS training programs that ran for a period of four months. Subsequent contacts with students and instructors facilitated entry into Medco and Maryville during the seventh month of the investigation. The study's phasing was designed around two comparisons. By studying volunteer and commercial agencies simultaneously, Nelsen sought not only to better determine whether dynamics observed in one type of organization were characteristic of the other, but to reduce the odds of failing to collect neces-

sary data. By studying pairs of agencies sequentially, Nelsen was better able to verify and refine theses developed during the study's initial phase.

Nelsen gathered data in each agency by attaching herself to a crew on duty at the time of observation. This strategy allowed her to experience the full range of activities that characterized EMS. Observations were spread over different times of the day and different days of the week to maximize the number of crews and type of calls observed. Periods of observation ranged from 4 to 8 hours. Considerable time was spent in bunk rooms and parked ambulances during which informal interviews occurred spontaneously. Observations and informal conversations were supplemented by over 20 audiotaped formal interviews with individuals and groups. To obtain the perspective of the EMTs' audiences, Nelsen formally and informally interviewed a number of emergency room nurses, physicians, physician's assistants, dispatchers, and fire fighters.

Over the course of the study, Nelsen participated in a total of 43 "runs" or "calls." All but two were with crews at Medco or Maryville, the two sites that officially permitted her to ride on their "rigs." Table 1 (which cross-classifies the calls observed by type of agency and minimum certification required to handle the call) indicates that the paid providers' work consisted primarily of routine transports or medical emergencies that required no more than a Basic EMT's training (89 percent). By comparison, a greater percentage of the volunteers' work required more advanced skills. Whereas 43 percent of the calls attended by the volunteer squads required EMTs with at least intermediate certification, only 11 percent of the paid agencies' workload was equally complicated.

Analysis of how skilled identities were situationally constructed began by collating all portions of field notes and transcripts that contained passages in which paid and volunteer EMTs discussed their views of themselves and each other. These passages were read and coded iteratively to identify themes that defined the two groups' identities and counteridentities. Particular emphasis was given to identifying claims common either to both volunteer agencies or to both commercial agencies. The actions that EMTs took in support of their images of self and other were analyzed similarly. All instances of calls or stories about calls answered by paid and volunteer EMTs were culled from the field notes and were separated by type of agency. The notes were then coded for behaviors that marked the practices of paid and volunteer EMTs. The coding focused on differences in the way the two groups went about their work and on how members of each interacted with members of the other. In short, the analysis was ordered by the primary features of the interactional model of skilled reputations discussed in the previous section. Our presentation of the data follows the same order.

Table 1
Seriousness of Calls Observed by Type of Agency

Minimum Level of Certification Required	Calls Handled By: Paid Agencies	Calls Handled By: Volunteer Agencies
Basic EMT or Less	32 (89%)	4 (57%)
Intermediate or Greater	4 (11%)	3 (43%)

$x^2 = 4.33$; df = 1; p = .04

V. Data

Identities and Counteridentities

Paid EMTs

EMTs at Jones and Medco held surprisingly similar images of themselves and volunteers. In each agency, identities and counteridentities were built around the informal distinctions that medicalization had brought to EMS: the paid agencies' higher volume of calls, the paid EMTs' greater training, and the fact that control almost always reverted to paid providers in the context of mutual aid. Out of these distinctions and the exigencies of everyday work, the paid EMTs had fashioned a coherent ideology of skill. The identities and counteridentities that lay at the core of that ideology were organized as sets of oppositions. What paid EMTs were, volunteers were not; and *vice versa*. Four contrasts were particularly salient.

Artistry vs. Habitual Practice. All paid EMTs were quick to note that most volunteers had far less experience than they. Consequently, they argued, paid EMTs could generally provide better care. The paid EMTs' claim to greater acumen rested less on their training than on the belief that they had encountered a wider variety of situations. As one of Medco's medics put it, "volunteers are no match for us because they don't have the experience under their belts. Their call volumes are just too low." Although a dedicated volunteer might compensate for lack of experience by studying journals and practicing with mannequins, paid EMTs claimed that few volunteers took such steps and that, in any case, simulation was a poor substitute for "the real thing."

EMTs at Jones and Medco insisted that emergencies were more varied and complex than textbooks or trainers could convey. Being skilled therefore meant more than being knowledgeable. "Real" expertise was viewed as a form of artistry born of interpretive finesse and the ability to innovate around the particulars of a case. Competent practitioners were said to be able to adapt their practice deftly to rain-soaked gullies, garbage strewn allies, cluttered living rooms, church pews, or any other setting where people became ill. In the paid EMTs' vision of skill, flexibility and resourcefulness reigned supreme. The staff of both agencies took pride in their ability to experiment with standard procedures and stretch the frontiers of practice. Tales of artisanship were staples of the culture at Medco and Jones. For instance, one of Jones' EMTs delighted in describing how he had gradually learned to avoid "blowing veins" when establishing intravenous catheters by experimenting with various angles of insertion. Because his technique proved more effective than that taught in training, Jones had reputedly changed its practice.

In sharp contrast, paid providers depicted volunteers as prisoners of their training, as creatures of habit and routine. "The problem with volunteers," commented one of Jones' EMTs, "is that they get caught up in . . . doing everything by the book. But its not always a textbook situation . . . you have to adapt to what's going on . . . and think of new ways to do things." Most paid EMTs felt that the volunteers' lack of experience and resourcefulness endangered patients.

Volunteer paramedics who were authorized to perform critical treatments but who lacked flexibility were said to be most dangerous of all. Nevertheless, according to the paid EMTs, the volunteers' inflexibility was less dangerous than their indecision.

Decisiveness vs. Indecisiveness. Although serious emergencies and dangerous situations represented only a small fraction of the workload, they dominated the paid EMT's perspective. A patient who deteriorated in transport or a victim whose attacker remained near the scene of the crime were archetypal images in the paid EMTs' subculture. They therefore extolled the ability to "size up a situation" quickly and act without hesitation. Indeed, as the following incident illustrates, once on the scene, paid EMTs worked with single-minded purpose:

> We arrived to find the victim being propped up by several onlookers. Another man, splattered with blood, was gesticulating wildly and insisting that the police do something. A small but unruly crowd had gathered. Bob warned, "This could get ugly." We sprang from the rig and ran to the scene. As Tim questioned the police, Bob led the victim back to the rig. Tim soon joined us, locking the rig's door behind him. Bob placed a cervical collar around the victim's neck. He then noted that the victim's pupils were constricted and that his breathing had become labored: he was 'going downhill fast.' The two began to work feverishly. Bob grabbed an intubation kit as Tim prepared an I.V. Without speaking, Bob stepped nimbly over Tim and took tape from an overhead cabinet. Hunched over the patient and straddled by Bob, Tim inserted the I.V. on the first try. Stepping back over Tim, Bob knelt by the patient and attached monitor leads while Tim inserted an oral airway. The patient gagged. Bob barked, "take it out" and, as if by magic, produced an ammonia inhalant from his belt and crushed it under the patient's nose. The victim recoiled and Tim slapped an oxygen mask over the patient's nose and mouth. Bob checked for a radial pulse but Tim told him not to bother, it was time to 'beat feet.' We sped off, arriving at the hospital in 3 minutes having traveled a distance of several miles.

By comparison, paid EMTs portrayed volunteers as slow. Their perception partially reflected the difficulty of assembling a volunteer crew. For instance, Medco's EMTs had made a litany of claiming that one has only eight minutes to revive and stabilize a victim of cardiac arrest." They argued that volunteers could not conceivably respond quickly enough. "It takes time for somebody to wake up, get their pants on, have a cup of coffee, and drive to the station," an EMT exclaimed. "Fifteen minutes have passed and the ambulance isn't even dispatched! By the time they get there, the patient . . . is brain dead."

However, even when on time, paid EMTs claimed that volunteers remained hazardous. Rather than act instinctively, volunteers were said to waste valuable seconds "analyzing the situation" and conferring among themselves before initiating treatment. Although it seems unlikely that volunteers could endanger patients to the extent that paid EMTs intimated, their behavior on the scene did contrast sharply with the behavior of their critics, as one of Maryville's calls illustrated:

> Because they had been talking and did not hear the dispatcher clearly, the crew began to dispute where to go. Fortunately, John piped up and said that he knew the place. Once the rig came to a halt everyone but Pam and I sprang from the rig and ran up the stairs. Pam, the EMT in charge, called to Phil and asked him to come back and help carry the

'jump kit' which everyone seemed to have forgotten. As we climbed the stairs with the stretcher, Pam grumbled that she had to break Phil of his habit of dashing off empty handed. In the apartment, an elderly woman sat on the couch surrounded by friends, family, and the rest of the crew. Although her breathing was labored, it seemed that nothing had yet been done: no vitals were being taken and the equipment was still in the jump kit. Pam began to take the vitals herself while issuing orders. John asked if Pam wanted the heart monitor. Pam said she wasn't sure. Maybe they'd better take the patient down to the rig rather than bring the monitor up. John went to get the monitor anyway. Pam told Phil to retrieve the stair chair arguing that the woman might remain calmer if she weren't put on the stretcher. Phil left. Pam put an oxygen mask on the patient's face, but the patient ripped it off. John came back with the monitor. Pam hooked up the leads and then noticed that 'something was wrong.' Every third beat appeared 'wild,' and there was a great deal of artifact. Although Pam attempted to reposition the patches and John tried new ones, neither was able to get the monitor to work. . . .

In Control vs. Out of Control. Paid EMTs proclaimed that to work decisively required more than experience; one also had to be "in control." Patients, bystanders, and even rescuers were said to experience strong emotions that compounded confusion at the scene of an emergency. A frantic spouse might increase a heart attack victim's anxiety or, if provoked, a concerned crowd could turn into an angry mob. Paid EMTs therefore insisted that their initial duty was to control the scene and prevent further disruption so that treatment could proceed. Informants felt that controlling oneself was key to controlling others. The paid EMTs openly admitted that they routinely experienced physiological reactions akin to an 'adrenaline rush' which, if not channeled, might cause them to act unprofessionally. Being in control was largely understood as a matter of demeanor, a question of how to present oneself to the public. For Jones' and Medco's EMTs, the appropriate face was that of a coolly detached authority, a role they prided themselves on being able to don on a moment's notice.

Paid EMTs maintained that, unlike themselves, volunteers were easily excited. Common topics for derision were the volunteers' purported habits of unleashing sirens unnecessarily, of nervously clicking the buttons on radio microphones, and of rushing to the scene without needed equipment. Although paid providers amused themselves during idle times by sounding sirens to annoy passersby, using a siren unnecessarily in the course of a call was taboo and sufficient reason for being made the butt of a joke. The extent of the paid providers' sensitivity to face was underscored one evening when one of Medco's EMTs mistakenly clicked his microphone several times and used a radio code reserved for volunteers. Other Medco EMTs stationed throughout the city heard the broadcast and responded by repeatedly clicking their own microphones to advise the offender they were aware of his gaff. The crew being observed laughed and declared that the EMT was guilty of the ultimate sin: reverting to a "vollie."

Public Servants vs. 'Trauma Junkies.' Closely related to the paid EMTs' image of themselves as coolly detached experts was their belief that one had to rise above the danger and excitement that often attracts newcomers to the occupation. Although Medco's and Jones' EMTs considered routine transports and minor illnesses unchallenging, they regularly proclaimed such work to be as important to the patient as a dramatic rescue. For this reason, they made much of their willingness to respond under any circumstance. In fact, Medco's EMTs routinely

noted, however grudgingly, that were it not for them, most of the city's disadvantaged would be without care. In short, EMTs at both commercial agencies viewed themselves as dedicated public servants.

Volunteers, on the other hand, were dismissed as "trauma junkies," individuals who lived for the lurid. Paid providers spoke of volunteers as sensationalists who ignored common emergencies but who turned out in force for automobile accidents involving multiple casualties and violent death. Medco's paramedics had made legendary a local squad that was unable to muster a crew to assist an elderly patient in respiratory distress. While in route, the paid paramedics purportedly heard a second call dispatched to the same township for a motor vehicle accident with multiple casualties. Six volunteers, including two paramedics and a critical care technician were said to have responded to the second call even though it occurred only a few minutes later. "These guys were sitting at home screening calls," concluded an informant, "I can't stomach such irresponsible behavior. These people [treat] EMS as a hobby... its a social thing where everyone sits around the station... . At 11 o'clock they go home. No one wants . . . an unexciting call when they have to get up for work the next morning."

Volunteer EMTs

The volunteers at Maryville and Lakeview readily admitted that their reasons for being involved in EMS were largely social.[7] However, in contrast to the paid EMTs, they viewed their orientation positively. Volunteers also appreciated the differences in training and call volume that the paid EMTs so prominently emphasized. But, whereas the paid EMTs used these distinctions to fashion a skilled identity, the volunteers employed them to construct a less than flattering counteridentity for their commercial counterparts. Thus, while volunteers and paid providers largely agreed on the differences that separated them, they disagreed substantially on what the differences signified.

Humanitarian vs Mercenary. Members of both volunteer squads vigorously claimed to be motivated by altruism. Individuals attracted by the lure of sirens and violent death were reportedly weeded out during socialization to yield a corps of dedicated humanitarians. To support their humanitarian claims, the volunteers routinely called attention to the fact that they received no compensation for their time and effort. Indeed, in comparison to paid EMTs, volunteers did appear to become more involved with their patients, as the following incident at Lakeview illustrates:

> Because the baby was stable, Lisa and Andy decided to transport immediately. They asked the mother to accompany them in the ambulance, but she said there was no one to stay with the other children. She knew few neighbors and had no phone to call for help. The older kids began to fuss. They wanted to go in the ambulance too. When Lisa said they could not, their whining became louder. Mitch calmed the mother by saying he'd stay with the kids and I offered to help. After the crew left for the hospital, I rocked the youngest child to quiet her. We settled on the floor where Mitch began to read to the older girls in an animated fashion. The next hour was spent reading, singing, and playing word games. When the girls became restless and asked for their mother, Mitch pulled worn photos from his wallet and told stories of his travels to Africa. Another half hour passed before we tucked the girls into bed. As we waited for the crew to return, Mitch became sullen, "This is the difference between paid services and volunteers. Paid people would just pick up the kid and go, but not the volunteers . . . one of us will always stay to keep an eye on the kids."

As if to underscore their own selflessness, the volunteers depicted paid EMTs as venal individuals whose salaried status had long ago eroded any altruism they may have once possessed. Among volunteers, paid EMTs were known as hardened mercenaries who rendered care arbitrarily. Volunteers claimed that Medco's crews routinely "bagged" (refused to take) calls because they were paid by the hour rather than the call. They also insisted that paid EMTs loitered about emergency rooms after delivering patients for unnecessarily long periods of time. Even trivial errands such as buying a pack of cigarettes or making a phone call were said to provide paid EMTs with an excuse to "go out of service."

Although the volunteers recognized that paid EMTs were more highly trained and had more experience than themselves, they claimed that high call volumes caused paid providers to become callous and perfunctory. According to volunteers, a repetitive case load eventually reduced patient care to a mechanical exercise devoid of compassion. Maryville's EMTs discouraged one of their colleagues from making EMS a career for precisely this reason. "Being a paramedic wouldn't be a bad way to make a living," counselled one colleague, "but after a while it would become a job and you'd stop caring about your patients." Another concurred, "I wouldn't want to become like the [paids] I know... they call themselves 'paragods.'" Paid EMTs did joke about being "paragods" when reflecting on the drama of the rescue, but the volunteers saw no humor in a term which they took as evidence for just how far hirelings could stray.

Insiders vs. Outsiders. Unlike commercial agencies, the volunteer squads served only their community and its surrounding area. Because the volunteers lived in Maryville or Lakeview and often worked nearby, their patients were usually acquaintances, if not family or friends. Since the two squads relied on the community as their primary source of funds and recruits, every patient was also a potential benefactor. It is therefore not surprising that EMTs at both agencies proudly portrayed themselves as devoted members of the community. Communal themes coursed through their tales of why they had joined: a desire to contribute to the greater good, the need to make friends, a way of becoming part of a new town.

Volunteers saw paid providers as outsiders who entered the mutual aid context with no interest in protecting the web of relations that the volunteers had so carefully woven. The tendency for paid EMTs to treat patients as "cases" particularly aroused the volunteers' ire. Confrontations between paids and volunteers were reportedly rare. Nevertheless, a Maryville crew was observed challenging a Jones' EMT who had growled at an uncooperative patient, "Look lady, bottom line, you can either calm down and talk to me or talk to the cops." When the Maryville crew later reproached the EMT for his abruptness, he replied, "So what! She was being a pain in the ass." Incensed, a volunteer spat back, "Hey man, *no one* talks to *our* patients like that!" If nothing else, viewing the paid providers as outsiders and themselves as community-oriented humanitarians enabled the volunteers to admit that the paid EMTs were more technically proficient without losing self-esteem.

The Alignment of Counteridentities

Like the elements of any ideology, the paid and volunteer EMTs' identities and counteridentities influenced how the two groups behaved and enabled each to make sense of the other's actions. But an ideological edifice could not, by itself, ensure either group's standing since their reputations ultimately hinged on the perceptions of doctors, nurses, patients, and the public at large. The EMTs therefore sought to persuade the members of various audiences to fashion counteridentities consistent with their own world view. To this end, paid and volunteer EMTs wittingly or

unwittingly pursued three strategies: (1) they behaved in a manner congruent with their identity in the hope that audiences would draw proper conclusions; (2) they constrained their counterparts to act in ways that communicated weakness; and (3) sometimes they actively sought to use each other as foils in order to bias an audience's perception of their counterparts. In each case, the paid EMTs had the upper hand.

Presenting a Consistent Face

Although the public makes no sharp distinction between paid and volunteer EMTs, anyone observing a mutual aid call would be hard pressed to ignore their different appearance. Paid EMTs wore trim, dark-blue trousers and shirts, black combat boots, and heavy black leather belts slung with holstered radios and utility pouches containing scissors, forceps, and other medical supplies. Their uniforms were adorned only by a small brass name plate, an identification tag, and a shoulder patch that proclaimed their agency and certification. Many paids wore stethoscopes around their necks. Short haircuts, well-trimmed beards, minimal make-up, and little jewelry completed an aura of austerity designed to communicate authority.

In contrast, because the volunteers dressed to taste, they struck a more casual pose, not unlike that of their patients. In fact, one would have had difficulty distinguishing volunteers from bystanders had it not been for their company jackets festooned with colorful patches and pins. The volunteers admitted that on many occasions they arrived on the scene improperly dressed. Two of Maryville's EMTs, for instance, responded to an afternoon emergency in business suits. The patient, who regained consciousness in route to the hospital, became alarmed that she was being kidnapped by gangsters. The crew could not convince her otherwise, for as the patient repeatedly noted, they didn't "look like doctors."

Differences in speech and practice paralleled the visual distinction. Paid EMTs consciously signaled expertise by speaking technically and dispassionately. Their oral and written reports were punctuated with medical terminology delivered quickly and concisely: "We have a 45-year-old-male, found unconscious and dyspneic." Although the volunteers also reported all essential information, they rarely spoke as crisply as the paids, and they usually described symptoms in everyday language, often paraphrasing the patient: "We have a 45-year-old male here. His wife found him lying on the floor. He was unconscious when we arrived. He seems to be having some trouble breathing." Paid EMTs considered colloquial reporting to be amateurish and berated colleagues who spoke "like vollies."

Paid EMTs subscribed to strict decorum, especially when transporting patients. In route, drivers turned off the radio and engaged family members in quiet conversation, typically probing for information on the patient's medical history. If no family member was present, the driver rarely spoke. After communicating with the hospital and completing any treatment, the attending EMT sat quietly by the patient and completed a written report pausing periodically to check the patient's status. Crews rarely conversed among themselves or engaged in other activities until they arrived at the hospital. The only exception observed was when one of Medco's paramedics read a newspaper during a routine transport after noticing that his patient was asleep.

Although volunteers also displayed considerable circumspection, norms of stoicism were less widely shared and were conditioned more by a concern for the patient than a concern for face. Thus, the volunteers' comportment was more frequently punctuated by shows of emotion and puzzlement. A number of volunteers were known for being "intense" or overly concerned with the patients' emotional well-being. Such persons might adopt the role of counselor

and "put a full-court press on the patient" throughout the ride. When perplexed, volunteers also expressed uncertainty. For instance, a Maryville crew once became confused because a patient, who had ingested a variety of medications, exhibited none of the expected symptoms. As the patient listened, the bewildered lead EMT (who was in charge of patient care) reflected, "Xanax should have bottomed out his blood pressure. I don't understand it." The crew joined in with potential explanations for the contradiction and a spirited debate ensued as the rig sped toward the hospital. In contrast, paid EMTs hid their qualms even when hopelessly confused. No paid EMT was observed discussing the particulars of a case or even intimating that he or she might have had reservations in the presence of a patient. Paid EMTs expressed doubt, fear, or ignorance only when offstage.

The paid EMTs' aura of proficiency was made dramatic by their almost choreographed division of labor which was based on an explicit but informal understanding of who was more competent at what. As the incident of the attack victim with weak vital signs (see above) illustrates, Jones' and Medco's EMTs coordinated rapidly in near silence. Paid EMTs seemed to attend fully to their own task while remaining aware of their partner's actions so as to anticipate any need for assistance. Paid providers explained that partners usually established "a system" that took advantage of each other's strengths and weaknesses without regard for status. For example, an EMT with extraordinary technical skill might initiate critical procedures on unstable patients while her partner, who was good with people, managed bystanders even though the latter outranked the former.

Although volunteer crews administered competent care, their interactions were far less seamless. Anxious crews occasionally failed to anticipate the needs of the lead EMT and had to be directed to perform tasks. In these instances, assistants would rummage frantically in cabinets or equipment bags for supplies while the lead EMT guided their efforts cautiously. Volunteers claimed that considerable diplomacy was required to coordinate a crew because volunteers valued equality as much as technical prowess. The complicating dynamics of politics and parity were brought to light at Lakeview when an EMT with equivalent certification but less ability than the lead EMT began to misapply a cervical restraint. The lead EMT interjected, "Hey Merv, don't you think you should tighten his body down before we tighten his head? You could be jerking on a broken neck!" Merv ignored the warning and continued in stony silence. Later the lead EMT condemned Merv for "giving him the silent treatment" and claimed that he would have intervened had Merv not had equivalent rank and considerable influence with the agency's leadership.

The paid EMTs' appearance, speech, demeanor, and technical aplomb formed an interactional platform from which they could assert themselves as medical authorities when the need arose. Paid EMTs behaved assertively when they believed patients or medical personnel unduly questioned their judgement. Patients elicited authoritative responses by failing to cooperate or by disregarding an EMT's medical opinions. Although reasoning firmly with a patient usually worked, as one of Medco's paramedics noted, recalcitrant cases required more stringent tactics:

> Sometimes we get middle-aged business types who think they know more than you. They'll be having a heart attack and still refuse to go to the ER. But if you act professional, you won't have any trouble. I start by asking about their business. . . . Then I say look, you got to where you are today by . . . being aggressive. Well, I got to where I am the very same way and I know what I'm talking about. So, trust me... . If you don't have your chest pains checked out, we're going to be back here in a couple of hours.. . but by then you'll

be in much worse shape and there may not be anything we can do to help you.

Paid EMTs transformed the legal requirement to act only under a physician's orders into a license to assert themselves with medical personnel. How one asked for orders was far more important than the fact that one had to ask for them. Although Jones' and Medco's staffs always *requested* orders from the hospital staff, especially when administering drugs, they routinely prepared equipment and calculated dosage and titration rates long before receiving confirmation. In those rare cases when a request was denied or when the paid EMTs believed that improper orders had been issued, they negotiated with the physician. "Out here we're the doctor's eyes," explained one of Jones' EMTs. "Because you're actually looking at the patient you can tell if they don't need something. Usually you can tell the hospital that and they won't argue."

Lacking the paid EMTs interactional footing, the volunteers argued that recalcitrant patients were more responsive to kindness than bullying. Volunteers almost always attempted to calm or cajole patients into compliance by reminding them of friends, family obligations, and so on. Rarely would volunteers mention the possibility of death. "Scare tactics" such as those used by paid providers were considered the last alternative to be used only to prevent self-destructive behavior. Volunteers were similarly less assertive with medical personnel, although EMS instructors routinely urged volunteers to intercede actively with physicians on the patient's behalf. Maryville's and Lakeview's EMTs usually waited for the emergency room staff to issue orders and generally avoided confronting hospital personnel over matters of patient care. Such reluctance was demonstrated when one of Maryville's crew mistook an ER nurse wearing no identification for an aide and refused to release their patient to her. The nurse became indignant and refused to accept the EMTs' reports. Embarrassed, the volunteers withdrew and debated for several minutes before electing a member to confront the nurse. Although the volunteers acted according to correct procedure, their intimidation did little to champion their role in the emergency care process.

Constraining Competitors

Behaving consistently in light on one's self image is an important means of promoting a preferred occupational reputation, but its leverage for aligning audiences' counteridentities is limited. Not only does a strategy of consistency require perceptive observers, but all contrasts between self and competitor remain implicit. Moreover, because behavioral consistency leaves an audience free to draw its own inferences, the audience may "misinterpret" the actor's message. Thus, the ability to constrain one's competitors to act according to one's own world view is a far more pointed means of building the cultural capital necessary for a skilled reputation. Ensuring that intended contrasts are explicitly enacted leaves the audience's perceptions less to chance.

When rendering mutual aid, Jones' and Medco's EMTs routinely constrained volunteers to act like they believed volunteers should. Because the paid crews had to travel greater distances, they usually arrived to find volunteers busily taking vital signs, applying splints or dressings, and completing initial reports. Although the volunteers could not administer more advanced treatments, their very industriousness suggested a license to act. Paid EMTs challenged this license by using the leverage of higher certification to scatter volunteers and minimize their further involvement. On entering the scene of an emergency, Jones' and Medco's EMTs strode directly to the patient with studied disaffection and little more than curt acknowledgement of the volunteers' presence. Once

stabilized, the patient was placed on a stretcher and loaded into the ambulance where the paids could continue treatment "free from distractions." Volunteers were left outside to police the scene or direct traffic. Jones actually banned volunteers from entering its rigs unless assistance was needed during transport. How effective such tactics were in reducing volunteers to the status of bystanders was well illustrated by a mutual aid call involving Medco:

> Four volunteers dressed in cutoffs and T-shirts were standing around the patient, radios and clipboards in hand. Jason and Sue nodded as they passed and crouched by the patient. As Jason introduced us and Sue pulled equipment from the jump bag, a volunteer told us that the patient had refused to go to the hospital. Simply replying "okay," the medics went to work. At Mike's request to "give us some room," the volunteers sat their equipment on the floor and drifted back, eventually settling side-by-side on the couch where, knees touching, they quietly watched the action. As soon as Jason had coaxed the woman into going to the hospital, the crew lifted her onto the stretcher and headed to the ambulance. The volunteers filed out and milled about the rig until Jason emerged from the back to tell them we were leaving.

When paid EMTs did allow volunteers to participate, it was usually to perform tasks that the paids wished to avoid. Work that fell to volunteers included physically taxing or repugnant tasks such as prolonged cardiopulmonary resuscitation or the suctioning of blood and vomit from a person's airway. Volunteers were also routinely asked to carry equipment, direct traffic, and pick up trash. The derogation was not lost on the volunteers who complained bitterly of being reduced to doing "shit work." Long-time volunteers who began EMS before mutual aid became common were particularly prone to frustration and outrage. However, reactions were tempered by the volunteers' knowledge that they were not only legally but morally bound to bow to the paid EMTs' higher certification, even if the paids' behavior made such subjugation unbearable.

Faced with such a situation, the volunteers' only means of constraining the paids' behavior was to avoid interacting with them entirely. Because crews were often dispatched with no more than a vague complaint, it was common for volunteers to arrive on the scene only to find a patient who required the aid of a more highly certified person. In such instances it was the volunteers' duty to request help. Although dispatchers would usually send a paid agency, a volunteer crew could ask the dispatcher to summon another volunteer squad known to have members with advanced training. One of Lakeview's crew chiefs, who reputedly disliked Jones' EMTs, apparently made such requests with regularity. However, as his fate evidenced, the strategy was risky. On one occasion, the chief required the services of a critical care technician (CCT) during a daytime emergency and asked the dispatcher to summon a volunteer squad even though it had but a single CCT. Although a number of fire fighters and Basics responded, the CCT did not and Jones had to be summoned anyway. After this incident the chief's judgement was questioned by his colleagues and Lakeview was temporarily ridiculed throughout the region.

Volunteers could also avoid playing by the paids' rules if they left the scene as soon as the paids arrived. Although neither Lakeview nor Maryville used such tactics, speedy departure was said to be standard practice among several volunteer squads in the region. Members of these squads apparently reasoned that by leaving the scene they not only made it impossible for the paids to degrade them, but by providing no assistance they made the paids' task more difficult. Ironically, the show of solidarity which was designed to anger and disadvantage the paid EMTs only left them mildly amused. "We show up at the scene," smiled

one of Medco's EMTs, "and 'Smalltown' says, 'Medco's here, let's go.' And they do! They pack up their stuff and go. I say, good riddance!" By withdrawing, the volunteers lost any opportunity they might otherwise have had to influence public perception.

Foils and Atrocity Stories

No matter how compelling the paid EMTs' rank-pulling may have seemed to disaffected volunteers, the reputational effects of such behavior ultimately hinged on the inferences other audiences drew. Although detached bystanders might have concluded that the paids acted more skillfully than the volunteers, there is reason to believe that stricken patients were less attentive to the behavioral contrasts that swirled around them. Moreover, since doctors and nurses never observed mutual aid calls, the paids' ability to constrain the volunteers at the scene had no effect on either group's standing in the medical community.[8] Thus, if paid EMTs were to shape the perceptions of patients, doctors, and nurses, aside from presenting a professional front they had no recourse but to do so by using the volunteers as foils.

Because the paid EMTs adhered to strict norms of decorum during an emergency, they rarely denigrated volunteers in front of a patient unless the patient first voiced concern over the volunteers' performance. However, if the patient broached the subject, the paid EMTs were quick to parlay even modest differences in demeanor or performance into sweeping contrasts that the most inattentive patient would have found difficult to ignore. As the following excerpt from Medco's field notes illustrates, such exchanges usually occurred with an air of conspiracy inside the ambulance out of the volunteer's view.

> Once in the ambulance, the patient angrily insisted that she was fine. She claimed she had merely stepped into the lobby for some air. The volunteers staffing the event saw her on the steps and thought she was in respiratory distress. Despite her protests, they surrounded her and began to administer treatment. Tom nodded wisely, acknowledged that she was fine and sympathized with her wish to be left alone. However, he explained, he now had a problem: "You're right, the volunteers were too anxious. It's obvious to *me* that you're okay. But now that treatment's been started, you really should go to the hospital. It's a technicality . . . but I'd really appreciate your help." The confirmation seemed to please the patient who then became calm and cooperative.

The paid EMTs were far more willing to disparage volunteers before nurses and physicians. Drawing a doctor's or nurse's attention to volunteers' blunders enabled the paids to assert solidarity with the medical staff by underscoring that the volunteers were not "professionals like us." Tales of error were told as "atrocity stories" (Dingwall 1977) delivered in collegial tone of incredulity. For instance, the crew described in the previous excerpt lost no time in calling the ER staff's attention to the volunteers' poor judgement. The ranking paramedic grumbled to the triage nurse, ". . . this was a waste of time. If the goddamn vollies hadn't swarmed all over her, we'd both be doing something useful now." The nurse sympathetically joined the protest by arguing that such impetuousness represented a public liability that needlessly increased the workload of both the EMTs and the medical staff.

In return, the paid EMTs were quick to support and capitalize on any complaint that the hospital staff might make of volunteers. For instance, one evening an ER nurse asked a Medco paramedic to advise her on how to handle a volunteer crew who had improperly treated a patient. Although the mistake was not serious, the nurse was

concerned about future incidents. The paramedic advised her to "go easy on them." Seizing the opportunity to use the volunteers as foils the EMT reminded the nurse, "they're just volunteers . . . you can't expect the same level of performance from them as you do from me."

Atrocity stories were only one way to impugn the volunteers before the medical community. Less fleeting was the paid EMTs' treatment of written reports. The only enduring trace of an EMT's involvement with a patient was the written report submitted to the hospital. These reports became part of the patient's permanent medical history. During the course of a mutual aid call, the volunteers usually completed such a report and gave it to the paid crew to deliver to the hospital. However, the paids seldom included the volunteers' report with their own. Instead, they either copied necessary information into their own document or disregarded the report entirely. In so doing, the paids essentially eliminated any trace of the volunteers' involvement in the case. In fact, volunteers' activities were only mentioned when paid EMTs believed that the volunteers had been negligent. By recording only the volunteers' mistakes, the paid EMTs increased the odds that medical personnel would perceive the volunteers as incompetent.

To promote one's self-image by treating competitors as foils requires that one have an audience for one's interpretation of a competitor's action. In this regard, the structure of mutual aid severely disadvantaged the volunteers. Once paid providers arrived, volunteers typically had no further interaction with either patients or medical staff. When volunteers did transport patients to the hospital, they could not use the paid EMTs as foils since, by definition, no paid agency had been involved in the call. Consequently, volunteers rarely had an opportunity to interpret for third parties the contrast between their behavior and the behavior of the paids. In fact, some of Lakeview's and Maryville's volunteers believed that their inability to countermand the paids had already allowed local physicians to form prejudiced perceptions. One of Maryville's critical care technicians mourned for the days when physicians and nurses were more forgiving: "There was a time when you brought a patient into the ER and the doctor or nurse would tell you that you did a good job. Now they just bitch about everything you forgot to do."

VI. Conclusion

Ideologies of proficiency and altruism, like those espoused by paid and volunteer EMTs, have long divided members of the medical community into competing camps. As medical sociologists would quickly note, those groups that have staked their identities on technical prowess have usually been more successful in garnering a skilled reputation and greater status. Hence, doctors are generally considered to be more skilled than nurses, surgeons more skilled than family practitioners, and registered nurses more skilled than licensed practical nurses. One might therefore argue that paid EMTs should have more easily acquired a skilled reputation if for no other reason than their competitors apparently failed to realize that technical rhetoric is more pragmatic than rhetoric of altruism. To be sure, the paid EMTs' rhetoric was more in tune with medical culture (Friedson 1970), but it would be a mistake to see their appropriation of the dominant ideology as determinant. As the history of homeopathy and chiropractic suggests, had the paids been perceived as unable to deliver on their promise, their professed identity would have been rapidly attacked as a sham.

However, the paids' actual proficiency was also, by itself, insufficient for establishing their reputation since some volunteers possessed equivalent skills and since most of their calls did not require advanced training. Institutional supports were similarly inadequate. Although most of the paid EMTs were more highly certified, no formal barriers to training confronted the volunteers. Furthermore, existing laws may have aided the paid EMTs in their bid for status, but they neither explicitly nor implicitly granted the paid EMTs a monopoly. In fact, if anything, the laws ensured that every volunteer agency had its own jurisdiction. Finally, EMS societies made no distinction between paid and volunteer providers and the public still remains largely unaware of the differences between paid and volunteer EMTs. In other words, none of the forces that theorists traditionally use to explain occupational reputations can by themselves account for why paid EMTs in some locales have gradually acquired a reputation for skill among some audiences. In fact, as the EMTs themselves would readily note, the cultural and institutional context offers a number of other plausible identities including that of ambulance driver and agent of social control.

We have argued that to understand how and why the paid EMTs were acquiring a reputation for greater skill requires one to treat cultural understandings, institutional supports, tasks, and even competencies as resources whose meaning and utility are discovered in the course of ongoing interaction. Paid and volunteer EMTs both drew on the constellation of existing resources to fashion their identities and counteridentities. More importantly, each group wittingly and unwittingly deployed the resources at their disposal in hope of promulgating their world view. Although the structure of resources and constraints may have dealt the paid EMTs a stronger hand, the hand only had value in the context of their situated relations with volunteers. Each

group's reputation was a joint product of its ongoing history of relations with the other. In fact, if anything, our portrayal of how the two groups' reputations are tied to situated interactions is oversimplified, for we have focused exclusively on actions and interactions that involve EMTs. Both groups' reputations also surely have been affected by the interactions and interpretations of nurses, physicians, and other interested parties that occur, as it were, on a completely different stage.

Ultimately, our intent has been to offer an analysis of EMS work as a caution to those concerned with how nascent or upskilled occupations acquire reputations for skill. Emergency medical technicians are paradigmatic of many lines of work born in recent years. Not only are EMTs "service workers," but their mandate revolves around the use of sophisticated instruments and the application of technical knowledge. Yet, even among technicians, skilled reputations do not necessarily flow automatically from either the tasks that they do or the social and cultural context. Instead, like all cultural understandings, their reputation seems to accrue from the situated actions of individuals who, however unwitting and constrained, have always been the agents of social structure (Berger and Luckmann 1967; Giddens 1984). The case of the EMTs suggests that even occupational reputations grounded in formal knowledge may be formed initially in a primordial social soup whose ingredients include objective competencies, cultural understandings and structural supports simmered in a broth of ongoing interaction. Realists and constructionists have both generally overlooked the possibility that none of these ingredients is *a priori* more important than the other. Ultimately, we submit that realism and constructionism would both benefit from the pragmatic tempering of interactionism. Perhaps the time has come to return the builders of occupational reputations to the construction site along with their tools and techniques.

Endnotes

[1] The distinction between technicians and technologists in medical laboratories provides an interesting case in point. Technicians typically have associates degrees while medical technologists have bachelor's degrees. Although hospitals consider technologists to be more skilled and lament the shortage of technologists, studies indicate few differences in the wages of technicians and technologists (Franke and Sobel 1970) or in the work that they perform (Scarselletta 1992).

[2] For instance, because technical work is culturally associated with the manipulation of machines and instruments, some job classification systems indicate that engineers have "specialized knowledge" while librarians do not (Steinberg 1990). Similarly, jobs that require contact with upper management are often rated as more complex than jobs that require contact with clients and patients, even though the latter may be more difficult to manage. To the degree that systems for classifying jobs rely on taken-for-granted notions of skill, they may yield bizarre outcomes, as when dogcatchers, parking lot attendants, and zookeepers are rated as more skilled than nursery school teachers and child care workers.

[3] Although identities and counteridentities have rhetorical force and are integral to occupational ideologies (Strauss et al. 1964), one should not assume they are merely rhetorical. Because identities and counteridentities are rooted respectively in the activities of members and audiences, they are rarely fictions in the sense of falsehoods. Instead, they represent the spin that interpreters place on events in order to make sense of them. Thus, one should not be surprised to find that practitioners and audiences agree on the "facts of the case," even though they may disagree vocally about what the "facts" mean. More to the point, the elements of a practitioner's identity are likely to parallel elements of the counteridentities that audiences construct for practitioners, even though they signify something very different for the two groups.

[4] In fact, as late as 1970 nearly 50 percent of all ambulance services in the United States were still associated with funeral homes (Palmer 1989).

[5] Although several ethnographers have examined EMS work (Metz 1981; Manson 1981; Palmer 1989), none have written of the distinction or conflict between paid and volunteer EMTs. All have confined their observations to paid agencies.

[6] In instances of cardiac arrest, CPR must be initiated within four minutes. Within the second four-minute period advanced life support must begin otherwise the patient is almost certain to suffer brain damage (American College of Orthopedic Surgeons 1987).

[7] Previous studies concur that altruism, communalism, adventure, and the opportunity to acquire skills all play a role in attracting and retaining volunteers (Oldham 1979; Gora and Nemerowicz 1991).

[8] Despite the rapid growth and generally accepted effectiveness of EMS, the EMTs worried about their legitimacy in the medical community and felt insecure about their niche among the allied health professions. Others have attributed such insecurities to the relative youth of the field (McQueen and Paturas 1990) and to the fact that EMS was conceived by legislation rather than research (Feuchel 1989).

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